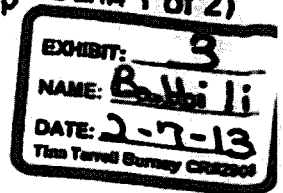


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CORRECTIONAL MANAGED CARE  
INTAKE HISTORY AND HEALTH SCREENING

1721640

## I. IDENTIFICATION

NAME: McCullum, Gary OCCUPATION: Driver EDUCATION: High School  
DOB: 04/04/53 COUNTY: McLennan PREVIOUS TDCJ #(s): \_\_\_\_\_

## II. FAMILY HISTORY

1 Blood disease (sickle cell anemia, hemophilia)	YES	NO	18 HIV Infections	YES	NO
2 Cancer	YES	NO	19 Intravenous Drug Abuse	YES	NO
3 Diabetes	YES	NO	20 Kidney Disease	YES	NO
4 Heart Disease	YES	NO	21 Liver Disease	YES	NO
5 High Blood Pressure	YES	NO	22 Mental Illness	YES	NO
6 Tuberculosis	YES	NO	23 Non Intravenous Drug Abuse/Abstinence	YES	NO
III. PERSONAL HISTORY			24 Psoriasis		
11 D1 Asthma/Emphysema	YES	NO	25 Rheumatoid Fever	YES	NO
2 Back Injury	YES	NO	26 Rheumatoid Arthritis	YES	NO
3 Blood Disease (sickle cell anemia, hemophilia)	YES	NO	27 Seasonal Allergies	YES	NO
4 Cancer	YES	NO	28 Sexually Transmitted Diseases	YES	NO
5 Cardiac	YES	NO	29 Smoker	YES	NO
6 Depression/Suicide Attempt	YES	NO	30 Tuberculin Immunization Data	YES	NO
7 Diabetes	YES	NO	31 Tuberculosis	YES	NO
8 Drug/Food Allergies	YES	NO	32 Unprotected Sex with Multiple Partners	YES	NO
9 Epilepsy/Seizures	YES	NO	33 Other		
10 Glaucoma/Hearing Aid	YES	NO	IV. OBSTETRIC/GYNECOLOGIC		
11 Gum Disease	YES	NO	AL HX		
12 Head Injury	YES	NO	1 Date of last menstrual period		
13 Heart Disease/Angina	YES	NO	2 Number of pregnancies/births		
14 Hepatitis	YES	NO	3 History of Problem pregnancy		
15 High Blood Pressure	YES	NO	4 Date of last sex abuse		
16 HIV + AIDS	YES	NO	5 Date of last mammogram		
17 HIV Test Date		NO	6 History of birth control methods (IUD, pills, etc)		
18 Homosexual/Bisexual Activities		NO			

## A. If YES to any of the above indicate family member or self, give date and treatment received

Father, Brother

## B. History of hospitalization?

YES ☒ NO ☐ Please list the DATE, HOSPITAL, CONDITION

Hillcrest Hospital

## C. Do you have any current medical, dental health or other complaints? YES NO

If yes, what

tooth pain, depression

## D. Have you experienced any of these symptoms: cough, weakness, weight loss, fevers, night sweats, loss of appetite or lethargy?

YES ☐ NO ☒ If YES, when?

## E. What illegal drugs have you used?

What was the mode(s) of use? (Please circle)

Smoking Injection Inhaled Ingested

What amount and how often did you use drugs and alcohol?

When was the last time you used drugs or alcohol?

Have you ever had withdrawal or seizures when you stopped using drugs or alcohol?

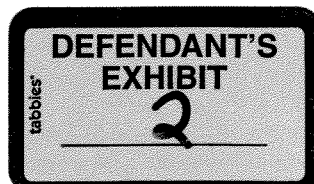
YES ☐ NO ☒

## F. Are you presently taking or supposed to be taking any prescribed medications?

If YES, what

See Med Sheet

HSM-13 (6/06)



## CORRECTIONAL MANAGED CARE INTAKE HISTORY AND HEALTH SCREENING

Reason for taking medications									
G	Observations	Tremor	YES	NO	Sweating	YES	NO	Other	
	Condition of skin	Cuts	YES	NO	Bruses	YES	NO		
		Sores	YES	NO	Other				
	Body & Movement	Deformities	YES	NO	Impaired Motor Activity	YES	NO		
		Other							
H BEHAVIOR AND MENTAL STATUS									
	Hygiene & Appearance		<input checked="" type="checkbox"/> Clean, neat		<input type="checkbox"/> Dirty, sloppy		<input type="checkbox"/> Other		
	Orientation (ask questions and document response)								
	What is today's date?		7/15/11						
	What time is it?		11:20 AM						
	What place is this?		Kauai						
	Speech	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Loud	<input type="checkbox"/> Soft	<input type="checkbox"/> Mumbling	<input type="checkbox"/> Other			
	Attitude	<input checked="" type="checkbox"/> Appropriate	<input type="checkbox"/> Laughing	<input type="checkbox"/> Crying	<input type="checkbox"/> Cursing	<input type="checkbox"/> Quiet	<input type="checkbox"/> Other		
I THOUGHT CONTENT (Please circle YES or NO)									
	Are you having current thoughts about suicide or self-injury?					YES	NO		
	Do you see or hear things that others do not see or hear?					YES	NO		
	Do you have any special powers abilities?					YES	NO		
	Do you receive personal messages from the TV or radio?					YES	NO		
	Do you have any phobias or excessive fears?					YES	NO		
J DISPOSITION									
	Routine referral to		<input checked="" type="checkbox"/> Medical	<input checked="" type="checkbox"/> Mental Health	<input checked="" type="checkbox"/> Dental	<input checked="" type="checkbox"/> CID			
	Immediate referral to		<input checked="" type="checkbox"/> Medical	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Dental	<input type="checkbox"/> CID			
	Release to general population		YES	NO	Other				
Offender Signature: Larry McCall Date: 7-15-11									
Reviewer Signature: D. Woodward Date: 7/15/11									